MEDICARE PART D
REPORTING REQUIREMENTS

This document describes the reporting requirements that CMS proposes to collect in support of Part D program management activities. The primary purpose is to list proposed reporting requirements and associated timelines. We are requesting that potential Part D Sponsors review the requirements and comment on the feasibility of providing these data for program management purposes.

Comments should be sent to PartDreporting@cms.hhs.gov by April 8, 2005, 5:00 pm EST. In commenting, please provide a contact name and phone number for any follow up by CMS. In addition, please be sure to identify **reporting requirements** in the subject line.

REPORTING REQUIREMENTS
DRAFT

Table of Contents

Introduction

In December 2003, Congress passed the Medicare Prescription Drug Benefit, Improvement and Modernization Act (MMA), allowing coverage of outpatient prescription drugs under the new Medicare Part D benefit. In accordance with Title I, Part 423, Subpart K (§ 423.514), the Act requires each Part D Sponsor to have an effective procedure to provide statistics indicating:

1) the cost of its operations
2) the patterns of utilization of its services
3) the availability, accessibility, and acceptability of its services
4) information demonstrating it has a fiscally sound operation
5) other matters as required by CMS

The purpose of this document is to provide an overview of CMS's proposed reporting requirements. This document represents our current expectations of data elements to be reported by Part D Sponsors at the Plan level (unless otherwise specified), reporting timeframes, and monitoring of Part D sponsors. According to Subpart O, sanctions may be imposed on Part D Sponsors who fail to comply with these reporting requirements.

The goal is to assure a common understanding of reporting requirements and how these data will be used to monitor the prescription drug benefit provided to Medicare beneficiaries. This document cannot be viewed as a final document. These requirements will be in effect for Contract Year 2006 and are subject to change at the discretion of CMS. This draft is being posted for industry review and comment, particularly from entities that anticipate offering Part D prescription drug plans. CMS expects to then release final reporting requirements by 4/20/05.

The following criteria were used in selecting reporting requirements:

1) Minimal administrative burden on Part D Sponsors
2) Legislative and regulatory authority
3) Validity, reliability, and utility of data elements requested
4) Wide acceptance and current utilization within the Industry

Reporting requirements are described in this document for the following areas: Enrollment and Disenrollment, Reversals, Medication Therapy Management, Generic Dispensing Rate, Grievances, Prior Authorization/Step Edits/Non-Formulary Exceptions, Appeals, Call Center Measures, Overpayment, Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions, and Licensure and Solvency.

Previous CMS guidance documents have also stated that each Part D Sponsor shall provide necessary data to CMS to support payment, program management, and quality improvement activities. Specifically, additional reporting requirements are identified in separate guidance documents for the following areas: formulary, TrOOP, coordination of benefits, payment and 1/3 audit, employer subsidy, low income subsidy, and Fallbacks.

Part D Sponsor Reporting Requirements

Section I. Enrollment/Disenrollment

Title I, Part 423, Subpart B includes statutory regulations regarding beneficiary eligibility and enrollment. CMS will request enrollment data as part of the monitoring of a Plan's availability, accessibility, and acceptability of its services. Part D Sponsors will be responsible for reporting multiple data elements related to beneficiary enrollment.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. Number of beneficiaries enrolled in the Plan as of the end date of the reporting period identified above. This should be a numeric field.
B. Number of beneficiaries who disenrolled for any reason from the Plan any time during the reporting period identified above. This should be a numeric field.
C. Number of beneficiaries who were involuntarily disenrolled from the Plan for failure to pay their premium during the reporting period identified above. Please refer to 423.44 (d) (1) for exact definitions and requirements. This should be a numeric field.
D. Number of beneficiaries who were involuntarily disenrolled from the Plan for disruptive behavior during the reporting period identified above. Please refer to 423.44 (d) (2) for exact definitions and requirements. This should be a numeric field.
E. Number of beneficiaries who were disenrolled from the Plan for providing false or incomplete information regarding other coverage. This should be a numeric field.
F. Number of beneficiaries who were disenrolled from the Plan because of death during the reporting period identified above. This should be a numeric field.
G. Number of beneficiaries who were voluntarily and involuntarily disenrolled from the Plan because of moving from the service area during the reporting period identified above. This should be a numeric field.

Section II. Reversals

Part D Sponsors will be responsible for reporting data elements related to claim reversals. Information on claim reversals will serve as a component in the monitoring of operational functions of Part D programs.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. Based on the time period specified above, provide the total number of pharmacy transactions with reversal as the final disposition. This should be a numeric field.
B. Reversed claim records must be maintained, and upon request, submitted to CMS.

Section III. Medication Therapy Management Programs

The requirements stipulating that Part D Sponsors provide Medication Therapy Management Programs (MTMP) are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D Sponsors will be responsible for reporting several data elements related to their MTMP.

Data related to the identification and participation in the MTMP will be submitted according to the following timeline:

	Period 1	**Period 2**
Dates of service	January 1 - June 30	January 1 - December 31
Data due to CMS/HPMS	July 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. The number of beneficiaries identified as eligible for the MTMP in the specified time period above. This will be a numeric field.
B. The number of participating beneficiaries in the MTMP during the time period specified above. This will be a numeric field.
C. The number of beneficiaries who disenrolled from the MTMP during the specified time period above. This will be a numeric field.
D. The number of beneficiaries who declined the offer to participate in the MTMP during the specified time period above. This will be a numeric field.
E. The total prescription cost for all MTMP beneficiaries on a per MTMP beneficiary per month basis. This will be a currency field.

Section IV. Generic Dispensing Rate

Cost control requirements for Part D Sponsors are presented in Title I, Part 423, Subpart D. Accordingly, Part D Sponsors will be responsible for reporting data elements needed to monitor utilization of generic drugs (defined by Title I, Part 423, Sub-Part A, § 423.4.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. Number of prescriptions for generic drugs dispensed (regardless of days supply) during the specified time period identified above. This should be a numeric field.
B. Number of total prescriptions dispensed (regardless of days supply) during the specified time period identified above. This should be a numeric field.

Section V. Grievances

Title I, Part 423, Subpart M of the regulation includes statutory regulations that require Part D Sponsors to maintain grievance information. Plans will be responsible for reporting data related to complaints received.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. For the time period identified above, provide the number of fraud and abuse complaints received. A fraud complaint is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Part D Plan, or beneficiary engaged in the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. This should be a numeric field.
B. For the time period identified above, provide the number of enrollment/disenrollment complaints received. This should be a numeric field.
C. For the time period identified above, provide the number of benefit complaints received. This should be a numeric field.
D. For the time period identified above, provide the number of access complaints received. This should be a numeric field.
E. For the time period identified above, provide the number of formulary complaints received. This should be a numeric field.
F. For the time period identified above, provide the number of quality complaints received. This should be a numeric field.
G. For the time period identified above, provide the number of marketing complaints received. This should be a numeric field.
H. For the time period identified above, provide the number of customer service complaints received. This should be a numeric field.
I. For the time period identified above, provide the number of pricing complaints received. This should be a numeric field.
J. For the time period identified above, provide the number of confidentiality/privacy complaints received. This should be a numeric field.
K. For the time period identified above, provide the number of appeal complaints received. This should be a numeric field.
L. For the time period identified above, provide the number of other complaints received. This should be a numeric field.
M. For the time period identified above, provide the total number of complaints received. This should be a numeric field.

Section VI. Prior Authorization, Step Edits, and Non-Formulary Exceptions

Title I, Part 423, Subpart D includes statutory regulations regarding drug utilization management programs. Plans that utilize prior authorization or step edits as utilization management tools (including for non-formulary exceptions) will be responsible for reporting several data elements related to these activities.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. Number of pharmacy transactions denied due to failure to complete step edit requirements in the time period specified above. This will be a numeric field.
B. Number of pharmacy transactions denied due to need for prior authorization (not including first pass step edits or early refills) in the time period specified above. This will be a numeric field.
C. Number of prior authorizations requested for formulary medications in the time period specified above (not including first pass step edits or early refills). This will be a numeric field.
D. Number of prior authorizations approved for formulary medications in the time period specified above (not including first pass step edits or early refills). This will be a numeric field.
E. Number of prior authorizations requested for non-formulary medications in the time period specified above (not including early refills). This will be a numeric field.
F. Number of prior authorizations approved for non-formulary medications in the time period specified above (not including early refills). This will be a numeric field.
G. Number of prior authorizations requested for tier exceptions in the time period specified above (not including first pass step edits or early refills). This will be a numeric field .
H. Number of prior authorizations approved for tier exceptions in the time period specified above (not including first pass step edits or early refills). This will be a numeric field.

Section VII. Appeals

Title I, Part 423, Subpart M includes statutory regulations regarding coverage determinations and appeals under Part D. As defined in §423.560, an appeal is any of the procedures that deal with the review of adverse coverage determinations made by the Part D Sponsor on the benefits under a Part D Plan the enrollee believes he or she is entitled to receive, including delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage. These procedures include redeterminations by the Plan and reconsiderations by the independent review entity (IRE).

CMS will request appeal data as part of the monitoring of a Plan's availability, accessibility, and acceptability of its services.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. Number of appeals submitted for **standard** redetermination in the time period specified above. This should be a numeric field.
B. Number of appeals submitted for **expedited** redetermination in the time period specified above. This should be a numeric field.
C. Number of appeals submitted for **expedited** redetermination that were granted **expedited** status. This should be a numeric field.
D. Number of appeals submitted for **standard** redetermination withdrawn by the enrollee. This should be a numeric field.
E. Number of appeals submitted for **expedited** redetermination withdrawn by the enrollee. This should be a numeric field.
F. Number of redeterminations resulting in reversal of original decision. This should be a numeric field.
G. Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **coverage determination**. This should be a numeric field.
H. Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **redetermination**. This should be a numeric field.
I. Number of IRE decisions for **standard** reconsideration resulting in reversal of original coverage determination or redetermination. This should be a numeric field.
J. Number of IRE decisions for **expedited** reconsideration resulting in reversal of original coverage determination or redetermination. This should be a numeric field.
K. Number of IRE decisions for **standard** reconsideration resulting in upholding of original coverage determination or redetermination. This should be a numeric field.
L. Number of IRE decisions for **expedited** reconsideration resulting in upholding of original coverage determination or redetermination. This should be a numeric field.

Section VIII. Call Center Measures

Part D Sponsors will report several data elements related to customer service center calls. This information will be utilized to monitor plan performance.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Part D Sponsor level:

A. For the time period specified above, provide the total number of inbound connections abandoned. This will be a numeric field.
B. For the time period specified above, provide the total number of inbound calls. This will be a numeric field.
C. For the time period specified above, provide the average speed of answer for calls. This is defined as the time it takes to get an inbound call connected to a customer service representative. This will be a numeric field (mm:ss).
D. For the time period specified above, provide the number of calls answered in ≤30 seconds. This will be a numeric field.
E. For the time period specified above, provide the average hold time for calls. This will be a numeric field (mm:ss).

Section IX. Overpayment

Part D Sponsors will be responsible for reporting data related to overpayments associated with Part D benefits.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	April 30	July 31	October 31	January 31

Data elements to be entered into the HPMS at the Plan level:

A. For the time period identified above, provide the total overpayment dollars identified to be recouped by the Plan. This should be a currency field.
B. For the time period identified above, provide the total overpayment dollars recouped by the Plan. This should be a currency field.

Section X. Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions

Part D Sponsors will be responsible for reporting multiple data elements related to rebates. These data will be monitored as components of a Part D Sponsor's operational costs.

Rebates, discounts, and other price concessions will be reported at the CMS contract level. For example, national contracts having multiple regional plans will only report rebate information at the national level. Rebate information should be summarized for each drug, rolled up to include multiple strengths, package sizes, dosage formulations, or combinations. Data will be uploaded through the HPMS.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	September 30	December 31	March 31	June 30

Part D Sponsors will provide an Excel file (filename=REBATES_(SPONSORNAME)_(CONTRACT)_(2006Q#).XLS, replacing '(SPONSORNAME)' with the Part D Sponsor's name, '(CONTRACT)' with the Part D Sponsor's contract ID, and '(2006Q#)' with the year and quarter number) which will include information related to actual rebate dollars in the following columns in the order as listed:

WORKSHEET 1:

A. MFG_NAME: For each rebate, provide the contracting manufacturer name. This should be a character field.
B. BRAND_NAME: For each rebate, provide the brand name. This should be a character field.
C. REBATE_REQ: For each unique manufacturer/brand name combination, provide the rebate amount requested. This should be a numeric (currency) field.
D. REBATE_REC: For each unique manufacturer/brand name combination, provide the rebate amount received. This should be a numeric (currency) field.

WORKSHEET 2:

A. Provide a separate worksheet that explains any differences between rebate amounts requested and rebate amounts received.

It is expected that the file specified above will summarize most rebate information. However, for all non-rebate discounts, price concessions, or other value adds such as gift-in-kind or other programs, Part D Sponsors will provide an additional Excel file (filename=DISCOUNTS_(SPONSORNAME)_(CONTRACT))_(2006Q#).XLS, replacing '(SPONSORNAME)' with the Part D Sponsor's name, '(CONTRACT)' with the Part D Sponsor's contract ID, and '(2006Q#)' with the year and quarter number) with the following columns in the order as listed:

A. MFG_NAME: List the name of each manufacturer for whom there is an associated discount, price concession, or other value add. This should be a character field.
B. DESCRIPTION: Describe the discount, price concession, or other value add. This should be a character field.
C. VALUE: Provide the value of the discount, price concession, or other value add. This should be a currency field.
D. JUSTIFICATION: For each discount, price concession, or value add, provide a justification for receipt. This should be a character field.

Section XI. Licensure and Solvency, Business Transactions and Financial Requirements

Title I, Part 423, Subpart I includes statutory regulations regarding Licensure and Solvency. Part D PDP Sponsors will be responsible for reporting multiple data elements and documentation related to their licensure and solvency and other financial requirements. Some data will be entered into the HPMS and other information will be mailed directly to CMS. These data will be used to ensure Part D Sponsors continue to be fiscally solvent entities.

Reporting timeline:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Dates of service	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31	Fiscal Year
Data due to CMS/HPMS	May 15	August 14	November 14	February 14	120 days after the end of the Plan's fiscal year

For materials that need to be mailed directly to CMS, please send them to the address below:

Centers for Medicare and Medicaid Services
Center for Beneficiary Choices
Medicare Drug Benefit Group
Division of Finance and Operations
7500 Security Boulevard
Baltimore, MD 21244

Financial and Solvency Requirements at the Part D PDP Sponsor Level:

A. According to the quarterly time periods specified above, Part D PDP Sponsors that are licensed will mail a completed Health Blank form directly to CMS.
B. According to the quarterly time periods specified above, Non-licensed Part D PDP Sponsors will mail un-audited financial statements, which convey the same information contained in the Health Blank form, directly to CMS.
C. According to the quarterly time periods specified above, Non-licensed Part D PDP Sponsors will mail documentation showing that an insolvency deposit of $100,000 is being held in accordance with CMS requirements by a qualified financial institution.
D. According to the quarterly time periods specified above, Part D PDP Sponsors not licensed in any state must submit a funding for projected losses worksheet to show they possess allowable sources of funding to cover projected losses for the greater of: 7.5% of the aggregated projected target amount for a given year or resources to cover 100% of any projected losses in a given year. This documentation should also take into account modifications of previous projections and show how they arrived at the aggregated projected target amount.
E. All Part D PDP Sponsors will mail a copy of their independently audited financial statements within one hundred twenty days following their fiscal year end directly to CMS.

Data elements to be entered into HPMS at the Part D Sponsor Level:

A. Total assets for the reporting period identified above. This should be a currency field.
B. Total liabilities for the reporting period identified above. This should be a currency field.
C. Total cash for the reporting period identified above. This should be a currency field.
D. Total cash equivalents for the reporting period identified above. This should be a currency field.
E. Total current assets for the reporting period identified above. This should be a currency field.
F. Total current liabilities for the reporting period identified above. This should be a currency field.
G. Total revenue for the reporting period identified above. This should be a currency field.
H. Total expenses for the reporting period identified above. This should be a currency field.
I. Total administrative expense for the reporting period identified above. This should be a currency field.
J. Total net income for the reporting period identified above. This should be a currency field.

K. Drug benefit costs Incurred But Not Reported (IBNR). This should be a currency field.
L. Drug benefit expenses. This should be a currency field.
M. Drug benefit revenues. This should be a currency field.

Appendix

Table 1. Summary of Reporting Elements

Note: this summary table is for quick reference use only. Please refer to the respective detailed sections for full definitions, timelines, and submission procedures.

Section	Element	Format	Frequency	HPMS
Enrollment and Disenrollment	Number of beneficiaries enrolled	Numeric	Quarterly	Yes
	Number of beneficiaries who disenrolled	Numeric	Quarterly	Yes
	Number of beneficiaries who were involuntarily disenrolled for failure to pay their premium	Numeric	Quarterly	Yes
	Number of beneficiaries who were involuntarily disenrolled from the Plan for disruptive behavior	Numeric	Quarterly	Yes
	Number of beneficiaries who were disenrolled from the Plan for providing false or incomplete information regarding other coverage	Numeric	Quarterly	Yes
	Number of beneficiaries who were disenrolled from the Plan because of death	Numeric	Quarterly	Yes
	Number of beneficiaries who were voluntarily and involuntarily disenrolled from the Plan because of moving from the service area	Numeric	Quarterly	Yes
Reversals	Total number of pharmacy transactions with reversal as the final disposition	Numeric	Quarterly	Yes
Medication Therapy Management Programs (MTMP)	Number of beneficiaries identified as eligible for the MTMP	Numeric	Semi-annually	Yes
	Number of participating beneficiaries in the MTMP	Numeric	Semi-annually	Yes
	Number of beneficiaries who disenrolled from the MTMP	Numeric	Semi-annually	Yes
	Number of beneficiaries who declined the offer to participate in the MTMP	Numeric	Semi-annually	Yes
	Total prescription cost for all MTMP beneficiaries on a per MTMP beneficiary per month basis	Currency	Semi-annually	Yes
Generic Dispensing Rate	Number of prescriptions for generic drugs dispensed (regardless of days supply)	Numeric	Quarterly	Yes
	Number of total prescriptions dispensed (regardless of days supply)	Numeric	Quarterly	Yes
Grievances	Number of fraud and abuse complaints received	Numeric	Quarterly	Yes
	Number of enrollment/disenrollment complaints received	Numeric	Quarterly	Yes
	Number of benefit complaints received	Numeric	Quarterly	Yes
	Number of access complaints received	Numeric	Quarterly	Yes
	Number of formulary complaints received	Numeric	Quarterly	Yes
	Number of quality complaints received	Numeric	Quarterly	Yes
	Number of marketing complaints received	Numeric	Quarterly	Yes
	Number of customer service complaints received	Numeric	Quarterly	Yes
	Number of pricing complaints received	Numeric	Quarterly	Yes
	Number of confidentiality/privacy complaints received	Numeric	Quarterly	Yes
	Number of appeal complaints received	Numeric	Quarterly	Yes
	Number of other complaints received	Numeric	Quarterly	Yes
	Total number of complaints received	Numeric	Quarterly	Yes
Prior Authorization,	Number of pharmacy transactions denied due to failure to complete step edit requirements	Numeric	Quarterly	Yes

Section	Element	Format	Frequency	HPMS
Step Edits, and Non-Formulary Exceptions	Number of pharmacy transactions denied due to need for prior authorization (not including first pass step edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations requested for formulary medications (not including first pass step edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations approved for formulary medications (not including first pass step edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations requested for non-formulary medications (not including early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations approved for non-formulary medications (not including early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations requested for tier exceptions (not including first pass step edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations approved for tier exceptions (not including first pass step edits or early refills)	Numeric	Quarterly	Yes
Appeals	Number of appeals submitted for **standard** redetermination	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination that were granted **expedited** status	Numeric	Quarterly	Yes
	Number of appeals submitted for **standard** redetermination withdrawn by the enrollee	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination withdrawn by the enrollee	Numeric	Quarterly	Yes
	Number of redeterminations resulting in reversal of original decision	Numeric	Quarterly	Yes
	Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **coverage determination**	Numeric	Quarterly	Yes
	Number of appeals submitted for IRE due to inability to meet timeframe for **redetermination**	Numeric	Quarterly	Yes
	Number of IRE decisions for **standard** reconsideration resulting in reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **expedited** reconsideration resulting in reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **standard** reconsideration resulting in upholding of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **expedited** reconsideration resulting in upholding of original coverage determination or redetermination	Numeric	Quarterly	Yes
Call Center Measures	Total number of inbound connections abandoned	Numeric	Quarterly	Yes
	Total number of inbound calls	Numeric	Quarterly	Yes
	Average speed of answer for calls	Numeric	Quarterly	Yes
	Number of calls answered in ≤30 seconds	Numeric	Quarterly	Yes
	Average hold time for calls	Numeric	Quarterly	Yes
Overpayment	Total overpayment dollars identified to be recouped by the Plan	Currency	Quarterly	Yes

Section	Element	Format	Frequency	HPMS
	Total overpayment dollars recouped by the Plan	Currency	Quarterly	Yes
Rebates	REBATES_(SPONSORNAME)_(CONTRACT) _(2006Q#).XLS	MS Excel	Quarterly	Yes
	DISCOUNTS_(SPONSORNAME)_(CONTRACT) _(2006Q#).XLS	MS Excel	Quarterly	Yes
Licensure and Solvency	Completed Health Blank form (for licensed Part D PDP Sponsors) OR Un-audited financial statements (for non-licensed Part D PDP Sponsors)	Mailed to CMS	Quarterly	No
	Documentation showing that an insolvency deposit of $100,000 is being held (for non-licensed Part D PDP Sponsors only)	Mailed to CMS	Quarterly	No
	Funding for projected losses worksheet (for non-licensed Part D PDP Sponsors only)	Mailed to CMS	Quarterly	No
	Independently audited financial statement	Mailed to CMS	Yearly (fiscal)	No
	Total assets	Currency	Quarterly	Yes
	Total liabilities	Currency	Quarterly	Yes
	Total cash	Currency	Quarterly	Yes
	Total cash equivalents	Currency	Quarterly	Yes
	Total current assets	Currency	Quarterly	Yes
	Total current liabilities	Currency	Quarterly	Yes
	Total revenue	Currency	Quarterly	Yes
	Total expenses	Currency	Quarterly	Yes
	Total administrative expense	Currency	Quarterly	Yes
	Total net income	Currency	Quarterly	Yes
	Drug benefit costs Incurred But Not Reported (IBNR)	Currency	Quarterly	Yes
	Drug benefit expenses	Currency	Quarterly	Yes
	Drug benefit revenues	Currency	Quarterly	Yes